Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TX Health dba Injury 1Dallas

Respondent Name
Freestone Insurance Co

MFDR Tracking Number
M4-13-1770-01

Carrier's Austin Representative Box
Box Number 19

MFDR Date Received
March 11, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In summary, it is our position that Dallas National Insurance has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered…"

Amount in Dispute: $562.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 23, 2012	97799	$562.50	$562.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Administrative Code §133.240 sets out guidelines for medical payments and denials.
3. Texas Administrative Code §134.204 sets out reimbursement guidelines for Workers Compensation specific services.

Issues

1. Did the requestor support claim was submitted in a complete and timely manner?
2. Is the requestor entitled to reimbursement?

Findings

1. Texas Administrative Code §133.240 (a) states, "An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the

insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation." Review of the submitted documentation finds;

a. Claim created and mailed on 8/23/2012 to Dallas National Insurance
b. Claim faxed on October 8, 2012, 6 pages including claim copy and documentation
c. November 20, 2012, Kristen King from Carrier gave new address to mail claim to
d. December 17, 2012, Kristen King to print and mail to Coventry
e. January 29, 2013 email sent to Kristen King as Coventry still had no record

Therefore the Division finds the requestor did support the claim was submitted in a timely manner. The disputed services will be reviewed per applicable rules and fee guidelines.

2. Texas Administrative Code §134.204(h)(5)(A)(B) states, "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.
   (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.
   (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

The documentation submitted finds on date of service 8/23/2012 a claim was submitted for a total of 4.50 hours with CPT Code 9799CPCA. The following shall be applied 4 hours x $125 = $500.00 plus .50 x $125 = $62.50. Total allowable equals $562.50. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $562.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $562.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 1, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.